



Memorandum

To: Mark Hennessey, Deputy Medicaid Inspector General for Agency
Coordination and Communication
Deborah Acanfora, Deputy Medicaid Inspector General for Audit

From: Healthcare Association of New York State
Home Care Association of New York State
LeadingAge New York
New York State Association of Health Care Providers

Subject: OMIG Proposed Certified Home Health Agency Audit Protocol

Date: January 16, 2013

Thank you for inviting our associations to review and comment on the draft “OMIG Audit Protocol – Certified Home Health Agencies (CHHA) (Revised December 14, 2012 and January 10, 2013),” and for meeting with us on January 7, 2013. The meeting was especially helpful in enabling us to discuss our initial reactions to the draft protocols, underlying issues, and areas for which clarification on both content and process would be helpful. The revisions to the December 14 draft reflect some of the broad issues/concerns raised at the January 7 meeting, and we are grateful for the changes.

As OMIG has requested, we now offer comment on this revised draft, which was received only mid-day Friday, January 11. Given the importance of these protocols to our members and the limited timeframe for comment, we request additional time to reach out to our respective members again for their comments. Their comments would be invaluable in order to help ensure the development of clear, accurate and fairly-applied CHHA audit protocols that everyone understands.

Broad-based Comments

We respectfully request that the following broad-based concerns and recommendations be considered, reflected and applied to all of the relevant protocols.

1. Consideration of Situation-specific or other Mitigating Circumstances

We appreciate the insertion of language in some of the protocols clarifying OMIG’s intentions to consider situation-specific or other mitigating circumstances in cases of compliance findings.

We respectfully request that this intention be reflected either as a prefatory statement applicable to all protocols (with any exclusions so indicated) or that the language be incorporated into those protocols where it is currently missing (e.g., protocol #6, relating to cases where there is no initial assessment in the record or assessment is late, and similarly for other protocols).

2. Reasonable Allowances for Adherence to Tasks and Time Frames

We appreciate the inclusion of flexibility reflected in compliance determinations with a number of the protocols. Such allowances/flexibility have been included in some of the protocols, but they are absent from other protocols where similar flexibility is also justified, particularly in the face of total payment recovery upon a finding when reasonableness would dictate otherwise. The 2008 version of the protocols provided for such flexibility for these other audit areas.

We recommend broadening the allowance/flexibility provisions to the additional protocol areas.

3. Proportionality of Disallowance to Compliance Finding

Emphasized during our January 7 meeting, and prior to, during and after the OMIG Working Group, was the need for proportionality of fiscal sanctions/recoveries to compliance findings, especially when medically necessary services were delivered in good faith by the provider.

OMIG has recognized in other contexts that a partial claim disallowance is often appropriate and has instructed its auditors accordingly (e.g., see the final “OMIG Audit Protocol – Office of Mental Health (OMH) Rehabilitative Services – Adults”). Yet the majority of the CHHA protocols continue to evidence an “all or nothing” approach to sanction, therefore lacking any sense of proportionality or recognition of services that were duly rendered (e.g., #6-10; protocol #6 would make a late assessment result in the full denial of payment of claims for medically necessary services that were duly provided and billed).

We respectfully request that proportionality be reflected as either a prefatory statement applicable to all protocols, or with each protocol for which recovery is at issue.

4. Non-compliant Personnel Documentation Does Not Justify Total Disallowances

In addition, the protocols include no parameters or limits on the auditors’ authority to disallow claims in full when documents are missing from an aide’s or caregiver’s personnel file (e.g. #27-34). This is troublesome for several reasons. First, here and elsewhere in the protocols, the requirements for operating a CHHA – in this instance, fully compliant personnel records – are essentially being converted into a condition of payment when there is no basis in the cited regulations or otherwise for linking those requirements to payments. Second, the protocols do not instruct the auditors to give the agency an opportunity to search and locate the missing documentation before the disallowance is effected. Third, the auditors could disallow the claim in its entirety even if the employee with the missing documentation may have provided only a portion of the hours or services for which the CHHA was paid.

5. Need for Clearer and More Circumscribed Parameters on the Role of OMIG Nurse Reviewers

The protocols suggest that the contemporaneous clinical decisions made in the field by the patient’s *own care professional* are subject to post-hoc second guessing and unilateral reversal by audit staff (e.g., #13, 17, 18 and 20). As written, these protocols would appear to have an audit nurse, who is not involved in the care of the patient or otherwise involved with the provider or situation, controverting the judgments of the care team’s nurse, other clinical staff or even the physician. Moreover, protocols #17 and 18 do not specify the “documentation” needed on audit to support the agency’s assessment of the medical needs of the patient, leaving instead much to the unfettered, subjective judgments of the auditors, retroactively, as to what level or type of documentation will suffice.

We respectfully request that this “secondhand” clinical review be removed as an audit function in its entirety or at least that the review authority be circumscribed and that deference be given to the contemporaneous judgments of the care team.

6. Documentation Compliance is Being Unfairly Measured by Subjective Review

As emphasized in the January 7 meeting, compliance with documentation standards is being measured by a subjective review process that is not otherwise circumscribed by the language of the protocol. In the absence of the use of documentation benchmarks providers will be held to the subjective review of OMIG staff about what constitutes desirable, acceptable or threshold level documentation of the care needed or provided. This approach also compromises the integrity of the overall audit process.

Given the known variation in clinical practice (documentation included) throughout the health and medical field, it is unfair to apply such documentation review based on unilateral opinion by audit reviewers over a clinician's level or content of documentation. This is particularly concerning given the significant consequences of any resulting payment denial.

We urge the elimination or substantial revision and circumscription of this audit aspect and in appreciation for Medicaid integrity concerns, urge extensive education sessions for providers on best practices in clinical documentation.

Protocol-Specific Concerns

While we appreciate the positive revision and effort in redrafting the protocols, we have preliminarily identified numerous areas within the individual protocols in which there is language that seems insufficient, vague or subject to differences in interpretation and warrant additional comments.

In order to ensure that we may provide you with protocol-specific comments as accurately and completely as possible, it is vital that we have reasonable opportunity to complete our vetting process with the field level providers and clinical staff. As a result of the ongoing challenges related to the overall home care system transitions to managed care, ongoing recovery efforts following Hurricane Sandy and limited human resources, understandably our members need more than a couple of days' turnaround to respond to these complex protocols and the various regulatory citations referenced to support them.

Accordingly, we respectfully request the opportunity for additional time on our protocol-specific comments and will provide this further written detail within the next two weeks.

Thank you for this opportunity to comment and for your consideration.

Submitted on behalf of the following associations and their statewide memberships which comprise the continuum of home and community-based care services and represent the vast majority of New York's CHHAs.

- Healthcare Association of New York State
- Home Care Association of New York State
- LeadingAge New York
- New York State Association of Health Care Providers